



Merced College
Allied Health
Physical Health Evaluation

Name		Date of Birth
Address, City, State, Zip		
Email Address	Phone	

To be filled out by Health Care Practitioner, Physician Assistant, or Nurse Practitioner

For the student's safety it is important to identify any family and/or personal history of current/past medical problems that would affect the student's ability to participate fully in an Allied Health Program. ***The CNA, LVN, RN, RT, SONO, RDA Programs require the student to be able to stand, bend, perform heavy lifting, and twist frequently in providing care to patients during procedures. Additionally, the student must be able to make rapid, sound decisions related to patient safety.***

Vital Signs: Temp. _____ Pulse _____ Resp _____ BP _____

Vision: R _____ L _____ Hearing: R _____ L _____

Heart: _____ Lungs: _____

Back Injuries/Deformities: _____

ABD: _____

Comments: _____

By signing below, I CONFIRM this patient's History AND Physical Condition adequate for them to fully participate in the Allied Health Program.

Date

Health Care Professional

Facility Stamp OR
Attach Provider Business Card